

Instructions Take Charge! Screening and Diagnostic Services Coupon

ODH Form No. 1342

For Approval fax to 405-900-7609 or Encrypted Email to CancerPCP@health.ok.gov

Please write neatly on the coupon using black ink. If a client has both a breast and cervical symptom, a separate coupon should be issued for the breast symptom and the cervical symptom.

Part 1	Demographics
Clinic name	Write the clinic name in this box.
Clinic site number	Write the four-digit number that is assigned to your clinic.
Social security number	Write the client's social security number. If the client does not have a social security number, write the word "NONE".
Age	Write the client's age on the date of the visit.
Last name	Ask the client to spell their last name and then write the information in this box.
First name	Ask the client to spell their first name and then write the information in this box.
MI	Ask the client their middle initial and then write the information in this box.
Maiden	Ask the client to spell their maiden name (if applicable) and then write the information in this box.
DOB	Write the client's date of birth in the following format MM/DD/YYYY.
Daytime phone number	Write the client's daytime phone number, including the area code.
Evening phone number	Write the client's evening phone number, including the area code.
Address, city, state, zip	Write the client's mailing address, city, state, and zip code. If the client does not have a mailing address, please enter a finding address (friend's address, significant other's address, etc.) contact information, and notate that it is a finding address.
Pregnancy information	Mark either "yes" or "no" if client is pregnant. If she is pregnant, enter due date.
Meets income guidelines	Mark "yes" or "no" if client meets current income guidelines.
Interpreter needed	Mark either "yes" or "no" if the client needs an interpreter.
Translation type	If the client needs an interpreter, please indicate the type. This will help the facility be prepared for the appointment.
Race	Mark "one" or "more" of the client's self-reported race.
Ethnicity	Mark the client's self-reported ethnicity.
Part 2	Current Breast and/or Cervical Finding
Procedure	Write the previously performed procedure(s)
Findings	Enter all information for breast or cervical finding or identified by the provider. Breast findings should be entered as follows: normal, benign, discrete palpable mass, bloody, or serous nipple discharge, nipple or areolar scaliness, or skin dimpling or retraction. Cervical findings should be entered as follows: negative for lesion/malignancy, LSIL, ASCUS, squamous cell carcinoma, AGC, ASC-H, adenocarcinoma, or HSIL.
Location	Enter the location of the identified breast or cervical finding.
Date	Enter the date of the identified breast or cervical finding.
Duration	Enter the length of time of the identified breast or cervical finding.
Part 3	Previous Breast and/or Cervical Diagnostic Procedure
Procedure	Write the previously performed procedure(s).
Diagnosis	Enter the diagnosis from the previous procedure listed above.
Date	Write the date of the procedure(s). If unknown, write the approximate date or unknown.
Facility name and contract information	Write the name of the facility and contact information if the client had a procedure from another facility for breast or cervical diagnostic services.

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Part 4	Service Requested
Breast services	Mark the service that the client needs. If a service is not listed on the coupon, then the service will not be covered by Take Charge!. Clients from County Health Department are only eligible for diagnostic services.
Cervical services	Mark the service that the client needs If a service is not listed on the coupon, then the service will not be covered by Take Charge! Clients from County Health Department are only eligible for diagnostic services.
Additional breast and/or cervical comments	Write any comments that would be clinically pertinent for the facility that is performing the service. For example, if a client has a personal history of breast cancer or if a family member has had breast cancer.
Part 5	Appointment Information
Date/time	Write the date and time of the client's appointment if known.
Name of facility	Enter the name of the facility that will provide the service for the client. Ensure that the provider is a Take Charge! contractor or the cost of the services will not be covered.
Phone number of facility	Enter the phone number (including the area code) of the facility that is providing the service.
Address of facility	Enter the physical address of the facility that is providing the service. Give a map or written directions to assist the client with finding the facility.
Additional appointment instructions	Enter information for the client that would be helpful, like instructions prior to having a mammogram or a colposcopy.
Part 6	Referral Information
Name of referring provider	Enter the name of the referring provider. Failure to provide information will delay receipt of results.
Referring provider phone number	Enter the phone number of the referring provider. Failure to provide this information may delay receipt of results.
Referring provider fax number	Enter the fax number of the referring provider. Failure to provide information will delay receipt of results.
Referring provider address	Enter the mailing address of the referring provider. Failure to provide this information will delay receipt of results.
Issue date/expiration date	Write in date the coupon was issued and the expiration date (60 days from issue of coupon).
Send report by	Mark fax to receive results by fax or mark mail to receive results by mail.

General Instructions for Referring Provider: The Screening and Diagnostic Services Coupon is completed at your facility. Once the coupon is completed, give the client two (2) copies to hand carry to the appointment. The original copy of the coupon should be filed in the client's chart. Remind the client to take the eligibility letter to the appointment. Any procedure other than a normal screening mammogram for women 50 and older requires approval from the Take Charge! Staff. Send 1342 to Take Charge! Staff for approval review via fax at 405-900-7609 or by way of encrypted email to CancerPCP@health.ok.gov.

General Instructions to the Take Charge! Diagnostic Provider: The client will hand carry two copies of this coupon to your facility on the day of appointment. Keep one (1) copy for your records and submit the other copy with medical documentation with monthly billing. Remind the client to take eligibility letter to the appointment.



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Take Charge! Eligibility Guidelines

To be eligible for the Take Charge! Program a woman must meet age, income, residency, and insurance status.

1. Age and Service Eligible to Receive through Take Charge! Program

Age	Service
21-49	Clinical Breast Exam (CBE), Pelvic Exam, and Pap Test (Women who are eligible for Family Planning Waiver should be screened through Family Planning Program)
21-49 (symptomatic of cervical cancer)	Clinical Breast Exam (CBE), Pelvic Exam, Pap Test, issue Screening and Diagnostic Coupon (ODH Form #1342) for cervical abnormalities
40-49 (symptomatic of breast cancer)	Clinical Breast Exam (CBE), Pelvic Exam, Pap Test, issue Screening and Diagnostic Coupon (ODH Form #1342) for breast abnormalities
50-65	CBE, Pelvic Exam, Pap test, issue Screening and Diagnostic Coupon (ODH Form #1342) for breast imaging
Over 65 years of age	CBE, Pelvic Exam, Pap test, issue Screening and Diagnostic Coupon (ODH Form #1342). Please use current clinical guidance from USPTS, NCCN, ACS and etc. to determine if screening is clinically necessary.

2. Income

A. Ask the client, "What is the total income for your family?"

B. Ask the client, "How many family members are supported by that income?"

Please note: The total family income includes: wages, tips, savings, net income from farm, self-employment, unemployment compensation, alimony, royalties, rental income, pension, retirement, savings, or bonds. Family income is any income or funds that the client has access to for the purchase of food, clothing, shelter, entertainment, or health care. If the client's total, household income is **more** than amount listed for the size of the family unit **they do not qualify**. There is no need to ask for proof of income by reviewing checking stubs, tax records, etc.

C. Compare the answers with the current Poverty Guideline table on the Take Charge! program website <http://takecharge.health.ok.gov>

3. Self-declared Oklahoma resident

4. Uninsured or have an unmet deductible of \$150.00 or more



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